Appendix I.

Department of Social and Health Services letter to Legislature regarding Medicaid Waiver Status

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

P.O. Box 45010, Olympia, Washington 98504-5010

December 31, 2003

The Honorable Helen Sommers
Chair, House Appropriations Committee
P.O. Box 40600
Olympia, Washington 98504-0600

Dear Representative Sommers:

This is to provide a status report on Chapter 29 Laws of 2003, E1, Section 2 (SB 6088) provisions that direct the Department of Social and Health Services (DSHS) to obtain a Medicaid Pharmacy Plus waiver. This waiver would allow the department to offer subsidized prescription drug coverage to low-income seniors and other low-income Medicare beneficiaries. DSHS also was directed to report to the Legislature on options to finance the waiver.

The recent enactment of the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (the Act) alters the need for a transitional Medicaid prescription drug benefit. The Act implements a new Medicare Part D prescription drug benefit coverage, which will provide prescription drug coverage to nearly all of the target population for this chapter law. It will provide low-income assistance to 70 percent of the target population. Under existing law, implementation of Part D coverage in January 2006 would trigger the termination of the Pharmacy Plus waiver within twelve months and make it unlikely that waiver budget neutrality requirements could be achieved. Based on available information, the federal Department of Health and Human Service's (HHS) Centers for Medicare and Medicaid Services (CMS) may withdraw the Pharmacy Plus waiver option. I am therefore recommending that we not proceed with obtaining a Pharmacy Plus waiver at this time.

CHAPTER 29, LAWS OF 2003, E1 (SB 6088) REQUIREMENTS

The Governor's 2003 request drug legislation (HB 1214) included a provision to obtain a Pharmacy Plus waiver to assist low-income seniors to obtain affordable prescription drug coverage until Congress adopted Medicare prescription drug coverage.

Chapter 29, Laws of 2003, E1 (SB 6088) adopted the Governor's recommendation and directed DSHS to implement a Medicaid prescription drug assistance program. The Medicaid prescription drug assistance program was intended to provide subsidized prescription drug

coverage to persons over age 65 with incomes up to 200 percent of the federal poverty level (FPL) and to other Medicare beneficiaries with incomes up to 200 percent of FPL. The program was conditioned upon necessary state funding and obtaining a Medicaid Pharmacy Plus waiver.

As a demonstration waiver, the drug assistance program was not to be a Medicaid entitlement program. Enrollment would be limited to funds appropriated for the program. DSHS was given authority to adopt a benefit design that is different than the existing full-scope Medicaid prescription drug benefit that includes over-the-counter drugs and supplies. The department was also given authority to adopt enrollment fees for the program and copayment provisions that are beyond the scope of existing federal Medicaid limitations.

The 2003 legislature did not appropriate funds for the Medicaid prescription drug assistance program. Instead, Chapter 29, Laws of 2003, E1 (SB 6088) directed DSHS to obtain necessary federal Medicaid waivers to finance the program. It also directed the department to identify and recommend financing options to the Legislature by November 15, 2003. Chapter 29, Laws of 2003, E1 (SB 6088) prohibited savings from implementation of premiums for Medicaid optional children to be used to finance the program.

The prescription drug assistance program was intended to be a transitional coverage program. Chapter 29, Laws of 2003, E1 (SB 6088) directed the department to terminate the program within 12 months after Medicare prescription drug coverage was implemented.

PHARMACY PLUS PROGRAM

In March 2002, CMS introduced a new 1115 demonstration waiver (called Pharmacy Plus) that allows states an opportunity to expand prescription drug coverage to certain low-income elderly and disabled individuals. The Pharmacy Plus waiver was part of the Bush Administration's strategy to help provide prescription drug coverage to seniors.

The waiver is limited to persons with incomes up to 200 percent of FPL. The waiver allows states to have a different prescription drug benefit design than is offered to regular Medicaid client, impose cost-sharing and enrollment fees, and to limit enrollment in the program to achieve required "budget neutrality."

Under the Pharmacy Plus demonstration, states are expected to expand Medicaid prescription drug coverage to low-income seniors (and disabled persons if part of the waiver coverage) and spend no more for Medicaid services to elderly persons enrolled in Medicaid (regular clients and

waiver clients) than the state would have spent for elderly clients in Medicaid absent the expanded pharmacy coverage.

Medicaid savings from the waiver are to be achieved by reducing the number of persons enrolling in the regular Medicaid program or reduce utilization of Medicaid acute, chronic and long-term care services for elderly persons. Budget neutrality must be achieved by the end of the 5-year demonstration period. This allows states to spend more federal and state funds for Medicaid coverage during the earlier years so long as savings are achieved by the end of the demonstration period.

To date, 16 states have submitted Pharmacy Plus waiver applications. Four states have approved waivers, 3 states have withdrawn their applications, 2 states have disapproved applications, and 7 states have pending applications.[1]

MEDICARE PART D COVERAGE [2]

The President signed the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" on December 8, 2003. The Act creates a new prescription drug benefit (Part D), Medicare program reforms, and certain Medicaid-related provisions.

Medicare Part D coverage will begin January 2006. Enrollment in Medicare Part D coverage is optional. Full-benefit Medicare/Medicaid dual eligibles who do not select a Part D plan will be automatically enrolled in a plan, but will have the option to decline enrollment or change plans.

There will be a 6-month initial enrollment period beginning on November 15, 2005 for all persons who are eligible for Part D on that date. Persons who become eligible after that date will have an initial enrollment period of not less than 6 months.

HHS will establish regions across the country where private insurers will bid to provide prescription-drug coverage to Medicare beneficiaries, either through a prescription drug-only

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[1] A General Accounting Office (GAO) study of Medicaid waivers raised serious questions about several approved states' Pharmacy Plus waivers being budget neutral.

[2] State agencies, National Association of State Medicaid Directors (NASMD), National Governor's Association (NGA), National Council for State Legislators (NCLS) and other public and private organizations are still reviewing the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" provisions. The overview in this letter is primarily from NASMD, NCLS, FamiliesUSA and Covington & Burling.

plan (PDP) or a comprehensive health plan. If no private plans bid to serve a region, then a HHS sponsored plan would provide coverage in that area.

PDP sponsors must offer coverage that is at least equal in value to a standard benefit, but some details may vary from plan to plan. The standard includes: a monthly premium of about $35, a yearly deductible of $250 and 75 percent coverage up to $2,250. There is no coverage for expenses between $2,250 and $5,100. Enrollees are responsible for paying entirely for $2,850 in expenditures (so called "gap" or "doughnut hole"). Above $5,100 the individual would then be responsible for either 5 percent co-insurance *or* co-pays; $2 for generic and preferred drugs and $5 for all other drugs, whichever is greater.

Each plan that offers Part D coverage will be permitted to implement a formulary, subject to certain requirements. A pharmaceutical and therapeutic (P&T) committee must develop and review the formulary. The formulary must include at least one drug within each therapeutic category or class of covered Part D drugs, based on a list of categories and classes developed by the U.S. Pharmacopoeia. The Act allows for the plans to exclude drugs for weight loss or gain, hair loss or excessive hair growth, and fertility, as well as over-the-counter drugs. However, smoking cessation drugs will be covered.

Medicaid federal financial participation (FFP) cannot be used to provide for drugs or cost-sharing for drugs for full-benefit eligibles (low-income persons with both Medicare coverage and Medicaid coverage that includes prescription drug coverage). There are seven classes of drugs that states can continue to offer to full benefit dual-eligible clients. A state choosing to offer other drugs offered by their Medicaid plan, which are not covered by Part D or the seven additional classes of drugs, can only do so at 100 percent of state expense.

The Act provides for low-income assistance for certain Medicare beneficiaries. For full-benefit dual eligibles with income up to 100 percent of the FPL, beneficiaries would pay no premiums, no deductibles, co-pays of $1 for generic and preferred drugs and $3 for all others. They also would be exempt from the coverage gap.

Beneficiaries who meet the asset test and earn below 135 percent of FPL ($12,123 for individuals, $16,352 for couples), would pay no premium and no deductible, with co-pays of $2 for preferred drugs, $5 for all others. They would be exempt from the coverage gap. The asset test allows for three times the current SSI standard ($6,000 for an individual / $9,000 for a couple). Reportedly, there is no cost-sharing for institutionalized individuals with incomes up to 135% of FPL.

A third group with individual incomes of no more than 150 percent of FPL ($13,470 for individuals and $18,180 for couples) would be allowed to have assets of no more than $10,000 individually, $20,000 per couple. They would pay some premium on a sliding scale up to $35, have a $50 deductible, coverage that paid 85 percent of costs up to the $3,600 limit and co-pays of $2 or $5 per prescription after that limit is reached. They also would be exempt from the coverage gap.

Under the Act, the Medicare program is to assume financial responsibility for Part D costs for full-benefit dual eligibles. However, states will be required to reimburse the federal government for a portion of states' share of the full-dual eligibles' drug costs. Under "phased-down state contribution requirements" (so-called "clawback formula"), states will be required to pay 90 percent of state cost in 2006, decreasing to 75 percent over ten years. States will be required to pay a per-capita amount for each full-benefit dual eligible that is enrolled in Part D coverage. The per-capita amount that states will have to repay will be increased each year, based on the national per-capita increase in Part D expenditures.

The clawback formula's cost implications for states are not yet known. States would have to only pay a percent of their state fund obligations. However, this savings could be offset by increases in Medicare per-capita drug costs that are greater than a state's drug costs for dual-eligibles. DSHS will be developing estimates for these costs over the next several months. State clawback payment obligations will begin in January 2006.

States and the Social Security Administration will both be required to administer eligibility programs for low-income assistance. DSHS will be facing an additional financial burden for conducting the eligibility reviews and enrollment activities related to the low-income assistance for Medicare beneficiaries. States will be able to treat these costs as Medicaid expenditures and receive regular administrative and IT FFP match rates.

Some states may also experience a 'woodwork effect' during the eligibility determination process. Applicants for the Medicare drug benefit may be deemed eligible for Medicaid. Between the clawback provision, the possible increase in Medicaid eligibles, and the additional administrative burden, some states may experience costs greater than they would have absent the Medicare prescription drug program, particularly in the first few years.

PART D & PHARMACY PLUS COVERAGE RELATIONSHIP

As described above, the Chapter 29, Laws of 2003, E1 (SB 6088) Medicaid prescription drug assistance program is intended to provide transitional, subsidized prescription drug coverage to persons over age 65 with incomes up to 200 percent of FPL and to other Medicare beneficiaries with incomes up to 200 percent of FPL. Based on 2002 Washington State Population Survey (2002WSPS) data for April/May 2002, there were approximately 186,000 seniors and 27,000 Medicare beneficiaries under age 65 with incomes up to 200 percent of poverty. Up to 181,000 (97 percent) of these 213,000 persons would be eligible for Part D coverage. Some of the remaining 5,000 persons may not be eligible for Medicaid Pharmacy Plus due to their citizenship status.

The Part D low-income assistance is available to Medicare beneficiaries with incomes up to 150 percent of FPL. Based on the 2002 WSPS, there were about 149,000 (70 percent of the Pharmacy Plus target population) persons with incomes within this range. We do not have resource information to know how many of these persons would meet the Part D low-income assistance resource requirements.

As described above, Pharmacy Plus waivers must achieve "budget neutrality" by the end of the 5-year demonstration period. Savings to finance the prescription drug coverage for seniors are to be achieved by reducing the number of persons enrolling in the regular Medicaid program or reduce utilization of Medicaid acute, chronic and long-term care services for elderly persons.

States, such as Illinois and Wisconsin that have approved Pharmacy Plus waivers, forecast that they would achieve necessary savings by either diverting persons from their Medicaid nursing home program or from their entire Medicaid program. It is assumed that providing prescription drug coverage to low-income seniors will divert some seniors by reducing the deterioration rate of their health status and reduced income due to high medical expenses.[3]

To date, only 4 of 16 states have obtained an approved waiver, while 5 have either withdrawn their application or have disapproved waivers due to budget neutrality. Given that there will be a Medicare Part D coverage and that up to 70 percent of Washington's target population may be eligible for low-income assistance, we believe that it would now be very difficult to achieve budget neutrality by providing financial assistance to persons with income between 150 and 200 percent of FPL, which is about 51,000 (24 percent) of the 213,000 target population.

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[3] Section V (page 18) of the CMS Pharmacy Plus application template.

Achieving budget neutrality is further complicated by time limits. In reviewing the four states with approved waivers, all four states estimate they will only achieve budget neutrality in the last year of the five-year demonstration period. Under existing SB 6088 provisions, DSHS would terminate the Medicaid prescription drug assistance program by December 2006. Assuming that the department was able to obtain an approved waiver and implement a program by July 2004, the state would only have two and one-half years to achieve budget neutrality.

PHARMACY PLUS WAIVER STATUS

In July 2003, CMS staff informally told DSHS that it would be advisable to delay submitting a Pharmacy Plus waiver application until after Congress completed its current deliberations on adopting Medicare prescription drug coverage. Given the recent enactment of the Act, CMS has not had time to rule on whether it would still entertain Pharmacy Plus applications.

Medicare Part D could replace having a Pharmacy Plus waiver. As outlined above, only about 5,000 (3 percent) of low-income seniors in Washington reported not having Medicare coverage that would qualify them for Part D coverage, and up to 149,000 (70 percent) of the Pharmacy Plus target population might qualify for low-income assistance.

The Act does not specifically address the status of Medicaid Pharmacy Plus waivers. The Act prohibits use of Medicaid FFP for full-benefit dual eligibles, but does not prohibit Medicaid financing of other Medicare beneficiaries with Part D coverage.

The Act does recognize that some states have pharmacy assistance programs. Under the Act, there will be a State Pharmaceutical Assistance Transition Commission. The Commission is directed to develop a proposal to address the transitional issues the state programs will encounter because of the enactment of Part D coverage. The Commission is to report its recommendations to the President and Congress by January 1, 2005.

CHAPTER 29, LAWS OF 2003, E1 (SB 6088) RECOMMENDATIONS

DSHS has not yet developed recommendations on financing options for the Medicaid prescription drug assistance program. The department would need to obtain an approved Pharmacy Plus waiver to determine the state fund costs required to support the program. We will not be able seek a waiver until CMS is able to advise states on whether they would still entertain such waivers.

Given enactment of the Medicare Part D coverage and low-income assistance, we believe that the Legislature should reconsider whether to proceed with such a waiver. The Pharmacy Plus waivers and associated prescription drug discount card programs provide transitional or bridge programs until Medicare enacted prescription drug coverage. With enactment of a Medicare senior drug discount program within six-months and Part D coverage by January 2006, it may be better for DSHS to focus its efforts on implementation of its new Medicare obligations.

We look forward to discussions with policy and appropriation committees on what actions we should take at this time.

Sincerely,

DENNIS BRADDOCK
Secretary

cc: Governor Locke
Douglas Porter
Tom Fitzsimmons
Bill Alkire
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